Underwritten by:
Industrial Alliance Insurance and Financial Services Inc.
400–988 Broadway W PO Box 5900, Vancouver, BC V6B 5H6

FOR OFFICE USE ONLY

APPLICATION FOR FAMILY ACCIDENT REIMBURSEMENT PLAN

Please complete, print and sign.

POLICY INFORMATION

Policyholder Name: Aon Reed Stenhouse

Group Policy Number: 100012192

School Board Name:

PARTICIPANT INFORMATION

Last Name | Given Name | Initials | Gender | Date of Birth (dd-mmm-yyyy)

○ Male ○ Female

Street Address | City | Prov. | Postal Code

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Telephone (Home) | Telephone (○ Work ○ Cell) | Email

SPOUSE INFORMATION

What is your spousal status: ○ Married ○ Civil Union ○ Common-Law, please provide date of cohabitation (dd-mmm-yyyy)

Last Name | Given Name | Initials | Gender | Date of Birth (dd-mmm-yyyy)

○ Male ○ Female

DEPENDENT CHILD(REN) IF YOU REQUIRE MORE SPACE, PLEASE ATTACH A SEPARATE SHEET OF PAPER, SIGNED AND DATED

Last Name | Given Name | Initials | Gender | Date of Birth (dd-mmm-yyyy) | Select one

○ Male ○ Female

○ Child ○ Full-Time Post-Secondary Student

Last Name | Given Name | Initials | Gender | Date of Birth (dd-mmm-yyyy) | Select one

○ Male ○ Female

○ Child ○ Full-Time Post-Secondary Student

Last Name | Given Name | Initials | Gender | Date of Birth (dd-mmm-yyyy) | Select one

○ Male ○ Female

○ Child ○ Full-Time Post-Secondary Student

BENEFICIARY DESIGNATION

The beneficiary designation stated on this application will supersede all prior dated revocable designations. Unless specific instructions to the contrary have been received by Industrial Alliance Insurance and Financial Services Inc., this designation will apply in the event of the participant's death to benefits payable under the participant's Accidental Death benefit in force under this group policy. You may change your beneficiary at any time without the beneficiary's consent, unless you specifically designate your beneficiary as irrevocable.

Beneficiary Last Name | Beneficiary Given Name | Relationship to Participant | % Payable to Each

Beneficiary Last Name | Beneficiary Given Name | Relationship to Participant | % Payable to Each

For any beneficiary under 18 you must also name a trustee (not applicable in the province of Quebec).

Name of Trustee

Unless otherwise stated in writing, the participant is the beneficiary for any spouse and/or dependent children Accidental Death benefits.

NOTE FOR QUEBEC RESIDENTS

If you have named your spouse (excluding common-law spouse) as your beneficiary, this designation will automatically be irrevocable.
This means that you will not be able to change your coverage without their consent.
If you do not wish your spouse's designation to be irrevocable, please check here → ○ **Revocable**

COST AND PAYMENT INFORMATION

Monthly Pre-Authorized Debit (PAD) I have completed the attached Pre-Authorized Debit (PAD) Agreement form authorizing Industrial Alliance Insurance and Financial Services Inc. (the "Company") to withdraw the required premium (plus applicable taxes) from my account.

Cost $39.95 per month

Billing Monthly

DECLARATION AND AUTHORIZATION FORM MUST BE SIGNED IN INK

I confirm that I have reviewed my application form in full and have read the Authorization.

I confirm that all applicants have provincial health coverage and are permanent residents of Canada.

I acknowledge receipt of the Notice on Privacy and Confidentiality (attached) summarizing certain privacy practices regarding collection, use and disclosure of my personal information.

I agree to the use of my personal information for the purposes outlined in this application. I understand that my consent to the use of any information to offer me products and services is optional and that if I wish to discontinue such use I may call or write to the Company at the telephone number or address shown on this application.

I confirm that the foregoing answers, forming part of an application for group insurance to the Company are true, full, complete and correctly recorded, and together with any other forms signed by me in connection with this application form the basis for any certificate issued hereunder. I understand that any group insurance arising from this application may not be valid if there is any incorrect answer or misrepresentation in this application. I agree that my insurance will not take effect until my signed and completed application has been approved by the Company and the first month's premium has been paid.

A copy of this signed authorization shall be as valid as the original.

X _____ _____

Participant Signature
(must always sign)

Date (dd-mmm-yyyy)

PRE-AUTHORIZED DEBIT (PAD) AGREEMENT

Please complete, print and sign.

PARTICIPANT INFORMATION

Last Name | Given Name | Initials

CHEQUE/ACCOUNT DETAILS FOR MONTHLY PRE-AUTHORIZED DEBITS

PLEASE ATTACH A PERSONALIZED 'VOID' CHEQUE OR COMPLETE THE INFORMATION BELOW.
IF YOU DON'T HAVE A CHEQUE, YOU CAN REQUEST A DIRECT DEPOSIT FORM FROM YOUR FINANCIAL INSTITUTION.

Name(s) of Account Holder(s) as shown on Financial Institution records

Street Address of Account Holder(s) | City | Prov. | Postal Code

Name of Financial Institution

Street Address of Branch | City | Prov. | Postal Code

PAD CATEGORY

IF THIS IS NOT FILLED IN,
THE PAD WILL BE TREATED AS PERSONAL

☐ Personal Expense ☐ Business Expense

Withdrawal Arrangement

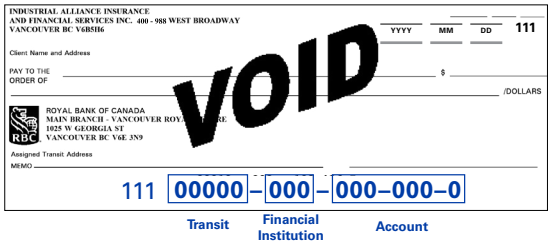
○ Fixed ☑ Variable

Transit Number (See sample ➔)

Financial Institution Number (See sample ➔)

Account Number (See sample ➔)

Sample ➥



Recourse

You have certain recourse rights if any debit does not comply with this agreement. For example, you have the right to receive reimbursement for any debit that is not authorized or is not consistent with this PAD Agreement. To obtain more information on your recourse rights, contact your financial institution or visit www.payments.ca.

AUTHORIZATION FORM MUST BE SIGNED IN INK

I/we, as the Account Holder(s), authorize Industrial Alliance Insurance and Financial Services Inc. (the "Company") and the financial institution named above or as indicated on the attached 'VOID' cheque, to withdraw variable monthly payments from my/our account, at the branch indicated, for the purpose of collecting premiums and any applicable sales tax for insurance under this policy.

The PAD amount will be debited from the account indicated above on the 1st day of each month or the next business day. I/we agree to notify the Company in writing, if there is any change to the banking information set out above.

I/we waive the right to receive pre-notification of the amount to be debited each month and the date of such debit. However, the Company will provide written notice of the amount of the first PAD at least three (3) calendar days before the first PAD is debited.

I/we may cancel this PAD Agreement at any time, subject to providing notice to the Company at the address provided below. This notification must be received at least ten (10) business days before the next debit is scheduled. I/we may obtain a sample cancellation form, or more information on my/our right to cancel a PAD Agreement at my/our financial institution or by visiting www.payments.ca.

I/we understand that cancellation of this PAD Agreement will not have any effect on the insurance provided under this policy, provided that payment is received when due and is made in accordance with the terms of this policy.

This PAD Agreement only applies to the method of payment. I/we understand that completing this PAD Agreement does not mean that the application for insurance coverage has been approved.

X

Participant Signature
(must always sign)

Date (dd-mmm-yyyy)

X

Signature of all other Account Holder(s)
(if a required signatory to this account)

Date (dd-mmm-yyyy)

NOTICE ON PRIVACY & CONFIDENTIALITY PLEASE READ CAREFULLY AND RETAIN FOR YOUR RECORDS

The information requested pursuant to this application and any additional information which may be subsequently requested by us, is required to process your application, and to process any claim for benefits made by you. To protect the confidentiality of such personal information, access to your information is restricted to you, any person authorized by you or authorized by law, and our employees, third party administrators, mandataries, agents or brokers, plan sponsors and any agents or brokers of such sponsors or other market intermediaries who are responsible for (a) sponsoring a plan for you, (b) marketing and administration of products or services, (c) investigation of claims. **Your file will be kept in our offices at the address indicated.**

You are entitled to review your personal information contained in our files, subject to certain limited exceptions established by law, and if necessary, to have it rectified by sending a written request to us at the address indicated: 400-988 Broadway W, PO Box 5900, Vancouver BC V6B 5H6, Attention: Manager, Administration, Special Markets Solutions. Corrections will be noted in the file. If a requested correction is in dispute, we nonetheless note your requested correction in the file. Further information on our privacy practices can be found online at ia.ca or alternatively, contact us at 1.800.266.5667 and request that a copy be faxed or mailed to you.

SEND YOUR COMPLETED FORM TO

SPECIAL MARKETS SOLUTIONS

Special Markets Solutions
Industrial Alliance Insurance and Financial Services Inc.
400–988 Broadway W, PO Box 5900, Vancouver, BC V6B 5H6

QUESTIONS?

Contact a Client Service Specialist at:
1.800.266.5667 (toll-free)
604.737.3802 (Vancouver)
solutions@ia.ca
Monday to Friday 6:30 a.m. - 4:30 p.m. Pacific Time